300 BASIC PROVISIONS/INFORMATION

300.1 GENERAL INFORMATION

This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

Questions, comments, or suggestions regarding this information should be directed to hfs.webmaster@illinois.gov

300.11 PURPOSE OF THE HANDBOOK FOR ELECTRONIC PROCESSING

This document is the Department's Companion Guide for the Health Insurance Portability and Accountability Act (HIPAA). It is not intended to replace any Implementation Guide but rather intended to be used in conjunction with them. It includes information relating to the following transactions:

Health Care Claim: Institutional	ASC X12N 837
Health Care Claim: Professional	ASC X12N 837
Health Care Claim: Dental	ASC X12N 837
Health Care Claim Payment/ Advice	ASC X12N 835
Health Care Claim Status Request and Response	ASC X12N 276/277
Health Care Eligibility Benefit Inquiry and Response	ASC X12N 270/271
Health Care Services Review-Request for Review and Response	ASC X12N 278
NCPDP	

300.2 ATTACHMENT(S) INFORMATION

Providers who submit electronic claims that require an attachment must continue to separately mail the paper attachment to the Department. NOTE: No other submission method (fax, e-mail, electronic) will be accepted at this time.

All attachments must be accompanied by the Electronic Claim Attachment Form cover sheet. Providers must report the "Attachment Control Number" in PWK06 of the 2300 Loop. The PWK identifier should be unique for each claim. Providers must use the same PWK identifier for all attachments that apply to the claim. Providers will not be allowed to use the PWK identifier more than once, even for re-submittals or rebills.

In order to re-associate the attachments with the electronic claim, providers must submit all attachments for a claim accompanied by one cover sheet.

300.3 VOIDS/REPLACEMENT INFORMATION

The Department will now accept bill type “7” (Replacement of a prior claim) and bill type “8” (Void/Cancel of Prior Claim).

The following data elements must match the original claim:

Document Control Number (DCN)	Loop 2300, REF02
Provider Number	Loop 2010AA, REF02
Recipient ID Number	Loop 2010BA, NM109

300. 31 INSTITUTIONAL - Void/Cancel of Prior Claim (Bill Type “8”)

If these elements match, the claim will be voided and the payment credited against a future voucher. If all three do not match, the transaction will be rejected.

300.32 INSTITUTIONAL - Replacement of a prior claim (Bill Type “7”)

If the elements for the new claim do not match the ones on the original claim, you must void the original claim with a Bill Type “8” and submit a separate replacement claim with the corrected information and the appropriate bill type (not 7 or 8).

300.33 PROFESSIONAL - Void/Cancel of Prior Claim (Bill Type “8”)

To void a single service line or an entire claim, enter Claim Frequency "8" in CLM05-3. If the DCN of the original payable or pending-payable claim, plus a Service Section of "00" is entered in REF02 of the 2300 Loop, the entire claim will be voided. If the DCN plus a Service Section number of greater than "00" from the original payable or pending-payable service line is entered, only that service line will be voided.

300.34 PROFESSIONAL - Replacement of a prior claim (Bill Type “7”)

To replace a single service line or an entire claim, enter Claim Frequency "7". If the DCN of the original payable or pending-payable claim, plus a Service Section of "00" is entered in REF02 of the 2300 Loop, the original claim will be voided and replaced with the information contained in the resubmitted 837. If the DCN plus a Service Section number of greater than "00" from the original payable or pending-payable service line is entered, only that service line will be voided and replaced with the new information contained in the resubmitted 837.

300.4 COORDINATION OF BENEFITS (COB) INFORMATION

300.41 INSURANCE IN ADDITION TO ILLINOIS MEDICAID

For those claims where the subscriber has insurance in addition to Illinois Medicaid, utilize Loop 2330B, REF02 to report the 3-digit HFS TPL code, followed by the 2-

digit status code. The complete list of TPL codes can be found in Chapter 100, Appendix 9 of the General Policy and Procedures Provider Handbook. For Institutional providers, the list of Status Codes can be found in Appendix 17 of Chapter 200 of Illinois' Handbook for Hospitals. For Professional providers the Status Codes are located in Appendix 1 of the Chapter 200 Handbook for your provider type.

300.42 Medicare Crossover Claims

Until the National Provider ID (NPI) is implemented, utilize Loop 2330B, REF02 to report the HFS TPL code for those claims where the subscriber has Medicare coverage, followed by the 2-digit status code.

	Code
Medicare Part A	909
Medicare Part B	910

The 909 or 910 Code, when utilized with the applicable status code, will assist HFS by clarifying the Medicare action.

300.43 COB - Reporting Prior Payment

Loop 2320 can be used for reporting amounts paid by another payer including Medicare. Loop 2330B can be used for Other Payer Secondary Identification.

300.44 Coordination of Benefits

The Department does not accept COB claims in the 837I format from any other payer, including Medicare. The Department does not accept COB claims in the 837P format from any payor other than Medicare carriers Administar Federal and Wisconsin Physician Services (WPS). Providers should submit claims to Illinois Medicaid in compliance with our current billing policies.

300.5 TECHNICAL INFORMATION

300.51 Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)

Unless specifically noted, the Department intends to follow all recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transactions may be included in any given transaction set (ST/SE), how many transaction sets may be within a functional group (GS/GE), and how many functional groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

300.52 Functional Acknowledgements

The Department intends to respond, in an appropriate manner and timeframe, to each transmission with an appropriate response. These responses can be in the form of a Functional Acknowledgment or in the form of a corresponding response transaction. For further information, consult the corresponding section for each specific transaction.

300.53 Validation of EDI Transmissions

The Department intends to perform validation on all EDI transmissions. This process will identify if a transmission contains certain error(s) that would make all or part of the transmission invalid based on the appropriate HIPAA Guideline(s). The Department intends to reject or accept transmissions at the transaction set (ST/SE) level and will provide an appropriate acknowledgment.

300.6 TRADING PARTNER AGREEMENTS

The Department will continue to maintain its provider agreements with its provider community. The Department has a somewhat unique relationship in that it does not currently exchange EDI directly with any Provider. The Department does however, exchange EDI with intermediaries such as Recipient Eligibility Verification (REV) vendors, Blue Cross/Blue Shield, Pharmacy switches (NDCHealth and WebMD), MCO's and its Dental Administrator and as such, the Department maintains agreements with these entities. Providers will not be required to enter into a trading partner agreement with the Department nor will they be required to re-enroll with the Department as a requirement of HIPAA.

300.7 NATIONAL PROVIDER IDENTIFIER (NPI)

Effective with claims received on or after 5/23/08, HFS will require the Billing Provider's NPI on all electronic claim submittals. If the Billing Provider's NPI is not reported, HFS will reject the claim. Atypical providers are not required to obtain or register a NPI, may continue to report their HFS number.

Effective with claims received on or after July 1, 2008, the identifier used for reporting a secondary provider id must be an NPI.

At this time, the NPI is not required for the Pay-to Provider (Payee). Providers must continue to report the 1-digit payee code to designate their appropriate payee in Loop 2010AB, REF02. If a NPI is reported for the Pay-To Provider (Payee), instead of the 1-digit payee code, the claim will be rejected.